

“THEY NEVER ASKED ME ANYTHING ABOUT THAT”

*THE STORIES OF WOMEN WHO EXPERIENCE DOMESTIC VIOLENCE AND
MENTAL HEALTH CONCERNS/ILLNESS*

*A report from the research project: Towards Better Practice: Enhancing
collaboration between domestic violence and mental health services.*

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Jude Irwin, Lindsey Napier



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BACKGROUND AND INTRODUCTION

Purpose of this report

This report outlines the experiences of a group of women who have lived with domestic violence and mental illness/health concerns. These women's interviews were part of the research *Towards Better Practice: Enhancing collaboration between domestic violence and mental health services*. Their stories make an important contribution to the development of knowledge about domestic violence and mental health and pinpoint changes that could lead to more comprehensive responses to meet the needs of these and other women who have similar experiences.

Towards Better Practice research project

The overall aim of the *Towards Better Practice* (TBP) research project was to enhance collaboration between domestic violence and mental health services with the anticipated outcome of improving service delivery for women who experienced both domestic violence and mental illness/health concerns. The three year study, funded by the Australian Research Council, was conducted by researchers in the Faculty of Education and Social Work at the University of Sydney in partnership with Joan Harrison Support Services for Women, Fairfield and Liverpool Mental Health Services, The Education Centre Against Violence and the Transcultural Mental Health Centre.

The connection between domestic violence and mental health concerns has been firmly established by numerous studies (Bonomi, et al., 2009; Carlson, McNutt, Choi, & Rose, 2002; Roberts, Lawrence, & Williams, 1998). However the very different histories, philosophies and organisational cultures of these two service sectors present formidable challenges to the development of effective working relationships and the sharing of different expertise (Gondolf, 1998). While coordinated or "joined up" approaches to domestic violence service delivery are commonly advocated, previous efforts to promote interagency collaboration have typically focused on the criminal justice system (Shepard & Pence, 1999). Less attention has been paid to the role of mental health services in responding to domestic violence. Yet failure by mental health services to recognise these connections and to respond appropriately to domestic violence can place women at risk of ongoing and escalating violence and compromised mental health (Humphreys & Thiara, 2003). Likewise, women's domestic violence services also have difficulty in responding to the needs of women with complex mental health concerns. This can be exacerbated by lack of access to services and other supports, placing such women at greater risk of homelessness and poverty, and the development of entrenched mental health problems (Astbury & Cabral, 2000).

The TBP research project comprised four interrelated and independent studies. These included: a self-completion *Practitioner Survey* exploring domestic violence and mental and health practitioners' responses to the co-existence of domestic violence and mental health concerns; *focus group interviews* which explored barriers to and opportunities for

collaboration, an *action research study* where domestic violence and mental health services developed and trialled collaborative initiatives, and *in-depth interviews* with women who have lived with domestic violence and mental health concerns. The stories of these women were central to the entire research project and form the basis of this report.

THE RESEARCH

Recruitment

During 2006 and 2007 women across NSW who: were 18 years or older; had experienced mental health concerns or had received a mental health diagnosis; and who had experienced domestic violence from an intimate partner; and were not currently experiencing an acute episode of mental illness, were invited to participate in the research project *Towards Better Practice* (TBP).

Domestic violence and mental health services across NSW were contacted about the research. They were asked to distribute flyers about the interviews to clients of their service who could then contact the researchers about participating. At all times women's safety and well-being were the priority for the researchers. A phone contact safety protocol was developed and all interviews were held at a place where both the women's and the interviewers' safety could be assured and risks to safety regarding discovery of their participation in the research minimized (e.g. in a private room in a women's refuge, or community mental health centre).

The interviews

A guided, open-ended interview schedule was developed in consultation with the collaborating partners and the TBP Advisory Group. The interview explored the women's experiences of using services from both sectors - domestic violence and mental health. The interviews were undertaken by three experienced researchers who had extensive knowledge of and experience working in the mental health and domestic violence sectors. Interpreters were used for interviews with women from culturally and linguistically diverse (CALD) backgrounds. The interviews were audio-taped and transcribed. The qualitative data analysis package NVivo was used in the thematic analysis of the interviews.

The women

Thirty three women were interviewed. Of these, five women were Aboriginal, eight women were from culturally and linguistically diverse backgrounds, and two women were immigrants from English speaking countries (England and the United States). The remainder of the women identified as Anglo-Australian. The women ranged in age from 18 to 65 years and lived in various parts of NSW. Due to the nature of domestic violence, many women had moved around the state. All the women have pseudonyms, most chosen by the women themselves.

Najat's Story

Najat, was married in the Middle East to a man who had returned there after he had been living in Australia most of his life. Two months after their marriage, they moved to Australia. They lived with his parents.

The emotional abuse started almost immediately. Najat was sent to work in the family business where she was controlled completely. Any activity that she wished to engage in had to be approved by the family. Najat became a slave and a prisoner in her own home. The abuse then extended to physical abuse by her husband. She was threatened with being sent back to her country of origin - for cultural reasons a very shameful act. As much as she missed her family, being sent back by her new family would have been a disgrace.

After living with her husband and his family for some time, Najat overdosed in an attempt to kill herself and was taken to the hospital. Her husband went with her, and told her not to talk about what was happening in the house or else she would wind up in a 'mental institution' and the family would go to jail. He said that when he got out of jail, he would kill her and then himself. She was frightened about going to an inpatient unit and so did not reveal to the hospital staff what was going on. Neither did she tell her extended family about what was happening because she felt so threatened. She did not tell the police because she was afraid it was her word against the family and she was not confident that the police would believe her or that they could help her.

When Najat returned home her mental health deteriorated. She became anxious and depressed. A follow up call was made by the Community Mental Health Service about the suicide attempt. The worker failed to use an interpreter and Najat's husband intercepted the phone call, informing the worker that Najat did not want to talk to them and did not need the service. He lied to the service provider saying that he was acting as the interpreter between them and Najat which he was clearly not doing.

Najat continued to live with the abuse until her husband's sister found out about the attempted suicide and her deteriorating mental health. It was fortunate for Najat that her sister-in-law, an ally, could speak English and tried to get her connected to appropriate services including a GP, the police and family support. Eventually, through her sister in-law's work, Najat came into contact with a worker from the Transcultural Mental Health Centre who spoke her language and who started to assist her with her journey away from violence, linking her to appropriate services.

LIVING WITH MENTAL HEALTH CONCERNS/ILLNESS AND DOMESTIC VIOLENCE

I think I must have post traumatic stress or something because all the violence and everything keeps going through my head all the time and I can't seem to move on from it (Yvonne).

Our mental health

The mental illness/mental health concerns the women described included: anxiety and panic attacks, depression and severe depression (experienced by over half of the women interviewed), insomnia, post traumatic stress disorder, bi-polar disorder, obsessive compulsive disorder, schizophrenia, and suicidal thoughts or actions. Women also discussed how their drug and alcohol issues coincided with their mental health concerns and experience of domestic violence. Many of the women interviewed had been diagnosed by a health/mental health professional and had been prescribed medication.

The violence we experienced

The women who were interviewed had collectively experienced most of the recognized forms of domestic violence. They had experienced: physical, verbal, financial, emotional, and sexual violence, stalking, intimidation, and threatening behaviour. Most women had endured more than one form at any given time. All of the perpetrators of this violence were men. Some of the women we interviewed also had children who had witnessed the domestic violence.

Making the connection

My panic attacks, amazingly, they started, amazingly, and I think he had, I think it's all got to do with him and how he treated me. Because the night I had my first panic attack was the day after we had our real, a major argument that I felt that we weren't on an equal footing (Isabeau)

The established connection between experiences of abuse and mental health concerns has been described in current literature. For example, Golding's (1999) meta-analysis of 40 studies of the prevalence of mental health concerns among women with a history of intimate partner violence found that victims of domestic violence are more likely to have symptoms of depression, anxiety and post-traumatic stress disorder, to attempt suicide, and to misuse alcohol or other substances than women not experiencing domestic violence.

The experiences of the women interviewed corresponded to Golding's findings. Many of the women interviewed had made the connection between the violence they had experienced at the hands of their partners and their mental health concerns even if health or mental health professionals did not. Most indicated that the controlling nature of the relationships, the constant blows to their self-esteem and the subsequent trauma they

experienced led ultimately to depression, panic attacks, anxiety attacks, PTSD, insomnia and suicidal thoughts and actions.

For example, Alkira had never had contact with mental health services before she met and lived with her abusive partner. She states:

I used to be strong. I wouldn't take no for an answer you know. But it does make you that little bit weaker ... The violence and then the mental health issues on top of it, which come as a result of it.

Denise also made a distinct connection between the abuser's actions and her onset of mental illness:

Because I thought this man must have done something to me or been treating me in a way that I must have freaked out or been that painfully abused by him that I did develop [a mental illness]. I don't know what he was doing, it must have been the verbal, put you down and you get a real low self esteem and depression sets in and you start wondering 'oh my god is someone watching me?' and things like that and it just goes on and on and on.

Stark and Flitcraft (1996) found significantly higher rates of suicide attempts among women who have experienced domestic violence. Angel describes the reality of this for women:

Very unstable, very traumatized. I was thinking that I was just useless. I was thinking of killing myself. I would rather die than to live this life ... I didn't feel like living anymore. I was exhausted. I was feeling sick everywhere and I hated myself actually because I thought why should I have believed this man in the first place?

Golding (1999) found that the more severe the abuse, the more severe the depression (five studies) and the longer women were away from the abuse, the greater the decline in their depression, demonstrating a close association.

Carla who lived with her partner who emotionally and financially abused her by taking all of her money for his drug habit, believes that her mental health improved dramatically after she had made the step to leave the relationship. She states that her mental health was much better: *Because I don't live with, my man anymore. I got quite depressed when I was with him.*

Other women also described the link between moving away from the violence and an improvement in their mental health. Kathy highlights this by stating:

I had a really bad depression last year and I came out of it and I felt a lot better and I suddenly realized it was because he didn't have any power over me.

BARRIERS TO SEEKING AND RECEIVING HELP

The women identified the barriers they experienced when they attempted to seek and receive help. These included: the responses health care professionals, the behaviour of abusers, complex service systems and other complicating factors.

Responses of Health Care Professionals

Humphreys and Thiara (2003) describe the difficulties for women who experience domestic violence when they come into contact with the mental health system. They comment that professional's responses range from 'the neutral to the negative'. A neutral response would include the psychiatrist recognising the domestic violence but refusing to treat the woman or seeing the partner as the one needing treatment (they saw no role for themselves in assisting the woman). On the negative end of the spectrum, women were often blamed for the violence, being labelled as having 'borderline personality disorder', leading to health care professional's failure to recognize the abuse and limiting their treatment. The women we interviewed described the types of responses from professionals ranging from both ends of the spectrum.

Don't ask, don't tell

The women discussed how GPs, psychiatrists and mental health professionals did not enquire about their current relationships, family life, or other social issues as a possible cause of the decline in their mental health. As a result, the underlying causes of the mental health concern (the domestic violence) were never addressed. The ramification for some of the women we spoke to was that they continued to be connected to the mental health system for years. More concerning was that women often stayed with the abusive partner in unsafe situations as they were not presented with any other alternatives.

For example, Isabeau talked about seeing various mental health professionals over a decade, but not one of them had enquired about domestic violence as a possible cause of her mental health concern. She talked about 'having her brain picked' for the myriad of different childhood traumas which could have caused her panic attacks, rather than asking about her current situation at home. In retrospect Isabeau was angry about this as she felt she told health professionals 'every secret' in her life, yet none of them picked up on the abuse she was experiencing from her husband. She knows that even though she didn't have the vocabulary or knowledge to name what was happening, they certainly did. For Isabeau, it was the police who recommended that she speak with a counsellor about her emotional abuse. When she describes the counselling, she stresses that it was the first

time that anyone had actually called it 'domestic violence' or 'emotional abuse'.

Um, so those professionals that I went to? I mean they are psychiatrists for Christ sakes. They're psychologists, they're therapists. Why did it take my son, and why did it take the cops and why did it take me coming to this centre [to name the domestic violence] after I had lived it? ... if I had gone to the first couple of therapists and if they'd picked it, well that would have been ..., that would have been like 10-11 years ago. I would have been out of there, instead of being with him for. It would have been ten years with him, not twenty years.

Similarly, when Denise was diagnosed with a mental illness at 22, her doctor did not ask her about her background or living circumstances which may have contributed to the illness. As she says:

They never asked me about my relationships and stuff like that. They never asked me anything about that, like how my living standards were or anything. They just came and gave me my injection and my tablets and that was it ... There was never any, 'Why'?

In her interview Denise went on to give advice to health professionals:

Like if she is having flare ups, why is she having flare ups and is it, you know if the medication is changing why is it changing. It is not because she is sicker, more unwell, maybe there could be triggers to why she is not well. Maybe she is getting the ear from the old man saying ra ra ra to her or bashing her or something. You know just to be more aware that there are other issues

Not listening

In addition to not asking women about the possible domestic violence, or about their social situation, the women talked about mental health professionals actively ignoring them when they tried to tell them about the violence.

Lily reported that her psychiatrist never asked about her history or the circumstances leading up to her depression:

Psychiatry hasn't come that far since performing lobotomies. One (psychiatrist) didn't know whether I drank because I was depressed or I was depressed because I drank and I tried to tell them that the old man was bloody punching me over and being cruel to the kids and I was too scared to escape and they didn't want to know.

When Duyen talked about her mental health treatment, she refers to staff talking about her symptoms (i.e. the headaches and suicidal thoughts) rather than their (probable) cause - the domestic violence that she experienced. She agreed that her treatment would have been more effective if they addressed her issues as a whole by acknowledging the violent history. She states:

They mentioned to me the strategies of getting rid of the idea of killing myself. They haven't mentioned to me about how to help myself as a victim of domestic violence.

Margaret felt frustrated at the mental health intervention she was receiving. *I had a mental health worker but all he wanted to do was teach me breathing and everything and not listen to what I was trying to tell him.* Again, Margaret felt ignored when she tried to tell the mental health professional about the domestic violence.

Treating the symptoms, not the cause

Women were often prescribed medication for their mental health symptoms rather than health professionals using counselling or other interventions to address past trauma experienced. At times the women experienced the use of medication as a tool of control by health professionals. For example Denise talked about denial of service if she didn't take her medication. After telling her psychiatrist that the prescribed tablets for depression were not assisting her in anyway, the doctor replied: *If you don't take these tablets I can't help you. I won't be seeing you if you don't take the tablets.*

Alkira talked about the local GPs and staff in the mental health service pushing anti-depressants on her when she didn't feel comfortable taking them. She says: *I spoke to the mental health team and when part of that was going on (the domestic violence), they just want to offer you drugs. I don't like drugs or taking tablets because they are only altering your mind.*

Whilst being treated for depression, Bahar tried to tell her psychiatrist about the abuse she had experienced and felt that: *I tried to tell them what was happening but they just said this is the cause and gave me medication ... They chose to ignore me.*

The Behaviour of Abusers

Tricked by the abuser

The women spoke of how their abusive partner would interfere with their contact with mental health services and subsequent treatment. They described how health professionals were often fooled by the abuser, believing his story over theirs. The consequence for women was that they were diagnosed and labelled, often with 'borderline personality disorder' which carried with it a number of ramifications. Although not limited to women from CALD backgrounds, it was one of the major issues of concern for the CALD women due to their limited knowledge of the Australian medical and welfare system, as well as their limited understanding of English.

For example, Bahar's husband would interpret between her and the psychiatrist, interfering with both what she felt comfortable to reveal, as well as what the psychiatrist understood, due to her husband's limited English. He further used his role to block the help-seeking efforts of Bahar who now blames herself for not getting help earlier for abuse of both her and her children which lasted twenty five years:

I went to doctors, I tried to get help, I tried hard to get help but my husband was interpreting and I was asking 'what do doctors say?' He has limited English and he was [undermining] my efforts to get help to improve my situation.

Kim's husband would have hold private meetings with her psychiatrist before she was diagnosed.

The bad one (service) was because my husband had already gone there prior. This practice was recommended by a local doctor and so my husband went and the things he said and all of that, so when I went I was basically diagnosed with borderline personality disorders and put on anti depressants and there was no support. When I went there, my husband was there and they were all like scared of me.

Trapped by the abuser

Often the abusive partners of the women would use the diagnosis of a mental illness/health concern to further the abuse and control the women. For example Kim's husband used her mental illness/health concern as a way to entrap her, using stigma and fear of mental illness to undermine her. He told the police and other service providers that she was crazy, paranoid, depressed and on medication.

Yes ... I did have a depressive episode but probably because I was so unhappy. He would go to the

doctor and say it was me and you go along with it ... Finally [when] I did tell people it seemed crazy. [Later] I did go for [a protection order] ... My husband went down and told the Police officer that I was crazy, and that I am depressed and I am on antidepressants ... I dropped the order because I thought there was no point. He is a very clever person, very intelligent. He is still highly regarded in the community. And people still think I am crazy.

Discrediting us as a way to keep control

Banu's husband would emotionally abuse her by telling her that she was crazy, as well as use her mental illness/health concern as a way to discredit her. He threatened to use the fact that she was 'crazy' against her, particularly if she tried to seek help for the domestic violence.

Because I used to go to a psychiatrist, he used to tell me I am crazy. He also sort of indirectly threatened me that [he] had support at the doctors. The Interpreter explained that this was a very strong threat to Bahar – along the lines of : 'I [can] get a report from the doctor or hospital that proves that you are crazy'.

Yvonne's abusive partner also used her mental illness to discredit her:

I talked to my GP the other day about getting anti-depressants. I'm worried about talking about to her – about suicide, suicidal things because at any time they could subpoena my medical records, which he has already done, and if that comes across in [Family] Court that I feel that I feel – I don't know. I could lose custody.

Justifying the abuse

The abusers also used the diagnosis of the mental illness/health concern as a justification for the abuse, constantly telling the women that because they were 'crazy' and unpredictable that they deserved the abuse. Kathy states:

I didn't ever use domestic violence services ... It really was that I was nuts and therefore it was legitimate! Whatever a husband did to me was legitimate and in fact that year 1983 was the year that two men who had murdered their wives got off because their wives had manic depression.

Complex Service Systems

They don't talk to each other

You've got to repeat your story and that all over again, like you sound like a nutcase I suppose, oh you just get sick of repeating it all the time (Alkira).

Lack of communication between the two service sectors has been identified in the literature as a major barrier for women seeking help for both domestic violence and mental health related concerns (Howard et al. 2010). Difficulties arose for the women when they used a number of services across the sectors. Many talked about services working separately with limited or no communication with each other which caused them confusion especially when they had to re-tell their story a number of times – causing them further distress.

Alanah found herself rehashing information or having to patch up communication gaps where one service promised to communicate with another to get something done but did not do so.

Because it is the same thing again. It is like Chinese whispers when something is said here and by the time it gets over to there, what are you talking about? ... there is not liaising with the other one [service].

Gondolf (1998) describes one of the key barriers to collaboration being the very different histories, knowledge bases and organisational cultures of each sector. Both domestic violence and mental health services work from differing theoretical underpinnings. The impact of this was evident when women talked about the inconsistencies in the way practitioners worked with or 'treated' them, which often created confusion. Ilke states that when one worker told her to do one thing she went away and practised that technique but then when she went to another worker their point of view was: *What are you doing that for? I would never have said (to do) that.*

Alanah received a plethora of different advice and treatments which were disjointed and sometimes conflicting. It was hard for her to sift through that advice, given that she trusted each of the people that she dealt with to be 'experts,' and accordingly she wound up with too much information, leaving her feeling confused.

It is always a disjointed service. You might have somebody and then they move on and you have to re-hash all over again ... which is unnerving and traumatizes yourself

Support is limited

Generally the lack of resources had a negative impact on service provision. This was particularly evident around access to services (waiting lists), lack of response (particularly with police and after hours mental health services), lack of generalist counselling for women (particularly women experiencing depression and anxiety who had limited access to the public mental health system where the focus is on acute mental illness), limits to the amount of time women were permitted to stay in refuge accommodation, lack of access to psychiatric treatment in rural areas, and limited follow up services for women once the 'crisis' was over. Sally recalled being thankful and relieved about being offered a spot in a counselling service:

I was lucky, but how many women are waiting six to eight months....you know I used to want to take my life day in and day out thinking I was crazy and I really believed I was crazy.

Other women were not so fortunate, describing the lack of availability of services as negatively affecting their mental health. The impact also carried on to children who had lived with domestic violence. Margaret talked about her daughter:

They said they were going to book her in but nothing was ever done and I thought that was not right because being that age and hearing and seeing everything – she needed that counselling – after doing the wrist and writing the suicide book. No one was taking any interest in what I was trying to let out – to say look she needs help too. Not just me, she does too.

Kathy discusses the difficulties associated with changes in staff who work for mental health services that she's accessed. She describes the staff turnover as being like a 'revolving door' and points out the difficulties in establishing trust with a new person as well as dealing with change:

You just get used to one and they go. Most people hate change but people with mental illness just don't deal with change. It is a trust thing. It is quite confronting to keep having to tell your life story to someone different. If you are in a vulnerable state you automatically assume they want something from you or have a hidden agenda. That is difficult.

Another source of abuse and control

When women described having issues with staff, they were usually specific to an individual domestic violence or mental health service. More generally, women had

negative experiences with police and statutory child protection services. Many described often cruel, disrespectful and non-trusting treatment by staff which mirrored the way they were treated by the abuser. Women who expressed unhappiness with the services that they had received commonly described feeling that either the service providers did not believe them about their experiences of domestic violence, depression or other mental health concerns/illness, or that they were unable to trust the service providers (have faith in their ability to provide assistance). For some women this resulted in feeling like they were alone in their struggle:

I had no help at all. I was on my own. It was like a war, a battle. I had to end it and see how I can get out of it. I didn't have help (Dani)

Issues of trust seemed to exacerbate mental health issues for some women, with the lack of trust in services the end of the line for some women, leading to anxiety and depression.

Katya talked about the blame she felt from workers in a refuge:

Every time when I go and push them to help me, they make me feel like I am a criminal, it is my fault.

Some women described feeling like they were a burden to the service providers. This sense of burdening the workers appeared to be caused, in part, by the attitudes of some of the workers described by some women as 'not helpful', 'judgemental' and 'rude'. Kim talks about staff at some domestic violence and mental health services believing that domestic violence only happens in lower-socio economic environments. She felt 'patronised' by staff: *Like you are poor and hard done by, ahh '... you poor thing.'*

Pumpkin describes very clearly the impact of mental health professionals treating women in a controlling way, rather than working with them.

I could almost swear that sometimes people are there just because they are sadistic and because they like to have control over other people. I have seen some men in the mental health business and you can tell they are there for the wrong reasons. You just know.

Complicating Factors

Women identified a number of factors in their lives that limited their access to services and support. These included: coping through drugs and alcohol, living in small rural communities, fear of losing children, language and cultural differences, stigma and shame.

Coping through drugs and alcohol

Like especially when one thing piles up on top of another. That's when I sort of just crash, I can't deal with it (Alkira).

Half of the women we interviewed described using drugs and alcohol as a way of coping with the violence as well as a way of medicating themselves to alleviate the symptoms of their mental illness/health concerns. However, the use of drugs and alcohol sometimes compounded the mental illness/health concern as well as having a negative impact on the women's overall health and well-being.

Golding's meta-analysis found that victimised women were almost six times more likely than non-abused women to misuse alcohol and five and a half times more likely to misuse licit or illicit drugs than other women (Golding 1999).

Carla and Sally both turned to alcohol to deal with their depression and the tremendous grief and loss they had experienced. Iona, Lea, and Ilke all used drugs and alcohol to deal with the long lasting effects of domestic violence as well as when the actual physical and sexual assaults occurred. Lea states:

I think you drink to block it out. I'm going to get drunk. This is my saying anyhow – I'm going to get drunk so I won't be able to feel it later. Not only I do it but a lot of people do it

Living in a small/rural community

Women described difficulty accessing services in small, rural, and remote communities. Some women lived great distances from town which made it difficult to attend counselling and groups that were located in town. Lack of transportation was a major obstacle in getting to support services. In some areas, psychiatrists would come to town weekly which often meant waiting weeks for an appointment. GPs were also hard to see and often moved around a lot. Women who had lived in the city and moved to the country made particular mention of the limited access to services in rural areas.

An additional compounding factor which proved to be a barrier for women seeking help was the lack of anonymity and everyone knowing everyone else's business. Alkira states:

I had to ring up the mental health in-take line the other day and I was like, once I done it, I thought, far out, what did I do that for? Cos, everyone in [the area] will know, you know, and that's how my thoughts were ... I was thinking shame, I know them people. I was thinking, I hope it's not someone that I know. And it does make you ... Probably, someone else in my case mightn't even do what I did. You know, made that phone call. But I needed, I needed to make it.

Margaret lived in a small country town and her abusive partner used her mental illness to turn the community against her, increasing the isolation she felt and undermining her self-esteem and confidence. She states:

He is a well known person in [town] and the names, the spitting, in a country town they believe him over me and it got that way that [my family support worker] had to come to Woolworths with me or shopping or whatever because it was that bad. The ladies behind the checkout would not give you the change, just throw it at you.

The prejudice against Margaret spilled over into the criminal justice system with a local magistrate denying Margaret an AVO due to his friendship with the abuser. Eventually she went to another town, court and magistrate to finally get an AVO.

Losing our children

A very real consequence for the women we interviewed was the potential or actual loss of their children. Domestic violence is a predicating factor for removal of children but in addition the abusers would use the women's mental illness to discredit her in custody disputes. Kathy states:

DoCS [statutory child protection] scares me because you never know who you are going to get, and you don't know how trained they are going to be and some of them have enormous powers and I do fear the ones who are frightened of mental illness. There are kids within that system who have powers of removal who actually, because they have not huge knowledge of mental illness are frightened of it and therefore a bit inclined to ... I know that sounds like a huge generalization but that is what I have seen.

Margaret's partner used drugs and alcohol as a way of discrediting her. She stated: *He made out I was a drunk or a drug addict, everything else, an unfit mother.* Margaret's children were removed and now live with the abuser.

Three of Carla's four children were taken away from her by DoCS due to the violence that was occurring in the home. She is still fighting to regain their custody.

Language and cultural differences

Newly arrived migrant women face additional barriers when seeking help for domestic violence (DVIRC, 1996). One of the major obstacles for women who had little or no understanding of English was the inconsistency in the use of interpreters by service providers. Banu explains:

Like sometimes when it's very, very, very important situations, an interpreter would come. But most of the times they wouldn't come.

In another example:

Shara, she came to the refuge with her two daughters and she was very frightened. She said "I need to go and get an AVO." She was Arabic speaking and said "please, let's go and get an AVO." They said "Wait." She was waiting four weeks for somebody to walk with her probably twenty metres to the Police Station, but finally they did and do you know what their excuse was? We can't find Arabic speaking interpreter. Can you imagine that?

Often the abusive partner acted as the interpreter which limited service provider's understanding of the extent and nature of the domestic violence and in turn women's access to support services. Najat who came to Australia to marry and had no understanding of English, was physically and sexually abused by her husband and was virtually a slave working in the family business. She was hospitalised following a suicide attempt but was too afraid to disclose the reasons for this at the hospital. Referral for follow up to a community mental health team was thwarted by her partner and his family because the service made telephone contact without using an interpreter.

As well as language barriers, women from CALD backgrounds talked about cultural issues interfering with both their help seeking to leave the abusive partner as well as appropriate treatment by services. Some women described family members who were not supportive of their decision to leave the abusers for 'old fashioned' or 'traditional' reasons.

For example, Duyen, an immigrant from Asia told the interviewers that her relatives in

Australia preferred she stayed with her abusive partner no matter what the circumstances. She received no support from her own family after she left the relationship and had to leave the state where she was living and move to NSW.

Najat was constantly being threatened by her husband that she would be sent back to her home country, for cultural reasons, a very shameful act. As much as her family overseas missed her, being sent back by her new family would have been a disgrace. When Najat finally decided that she wanted to separate from her husband, her father, brothers and extended family put pressure on her to stay in the relationship and to have a baby with the abuser. She states:

And in our culture it is hard. You can tell people but they don't help you in a situation like this.

Often cultural differences were not acknowledged or respected by service providers. The women talked about 'concepts' being very different in Australia to their country of origin which made it difficult to open up to service providers who didn't have an understanding of those concepts.

Talking, no problem. They talking, talking language talking, very comfortable. English very hard, you know why, change sometimes, no understand ... different country, different thinking.

Banu's interpreter went on to further say:

The people who have been helping her and treating her... if they do not understand the culture, the language, the situation, they can't help her.

For Banu, talking to a mental health worker who spoke her language, understood her cultural background and the nature of domestic violence was the beginning of a long road back from depression involving several suicide attempts.

Stigma and shame

Stigma was an issue for women with a diagnosed mental illness. Many reported not being believed about the violence and were treated disrespectfully. Lily felt like she was treated poorly as a result of her mental illness and commented how she received more sympathy for her physical illness (cancer) than she ever did when she was suffering with mental illness.

The Indigenous women interviewed described how shame interfered with seeking help for domestic violence. Shirley described feeling 'shamed and embarrassed' about the

violence she had experienced, particularly when she would have to walk around with black eyes. Lea states:

Shame is very important in Aboriginal culture- shame if I go and tell them, shame for saying that. And we try to teach the young ones that its nothing to be ashamed about because it happens to a lot of people.

Some of the women from CALD backgrounds also felt ashamed to use services and have others outside of their family know intimate details of their lives. Bahar states:

If you go to the women's refuge or Department of Housing, everybody knows. I would like to have my life in a dignified way and confidential because I don't want other people to know my situation.

Pumpkin theorized that part of the reason that abused women were stigmatized was because the general public were not educated about domestic violence. She felt that victims might be treated differently if the public were educated about the frequency of domestic violence in Australia and its impact on women.

WHAT WORKS?

The women commented on what they thought worked well. This included: co-ordination of support services, personalised support and trust, proactive, informed services and staff, availability of support, flexibility, hearing other women's stories, building a new life, working in a holistic way, and increasing public awareness.

Coordination of Support Services

They [services] all connect. It's really good ...to interact like that! (Lea)

In responding to the fragmented service delivery that they had received, women talked about the need for coordinated services that could work together to support them. They talked about a range of services not only those related to mental health and domestic violence, indicating that all services designed to assist women in their journey away from violence and with their recovery from mental illness/health concerns need to be connected on some level. The women asked that support staff be more knowledgeable about local services available thereby providing well-informed, comprehensive assistance.

The biggest thing is making it all work together (Brooke)

When asked about how services could be improved, Dianne talked about a more connected group of services so that women could have domestic violence counselling/advice, generalist counselling services, and mental health services within the same group of providers. The key, as Dianne suggested, was that these services be aware of one another's existence and expertise.

Having somebody in that field to talk to, who knew exactly ... So coming here for domestic violence but then having an outreach for some other form of counselling if you are really badly stressed, or if you feel like you want to kill yourself. Or if you are talking to the domestic violence counsellor and she says "how are you feeling?" and you say "oh I feel like shit. I just want to kill myself." Having somebody else to speak to, I would say [would be helpful] or having mental health worker they can refer you to.

Linda talked about her experience with a domestic violence service and her mental health worker. She spoke of the mental health worker being conscious of maximising her time and making sure that she did not duplicate information that she was already receiving

from other sources. This example highlights the importance of coordination of information at an individual worker level, informal as it may be. The result was that Linda had confidence in the worker, describing her as *'absolutely fabulous'*.

Personalised Support and trust

Women talked about instances of personalised, individual support and suggested that if services were looking to improve, they could move to work with women in this way. Examples of this type of support included accompanying women to stressful or difficult appointments (doctors' or court appearances) and advocating for women when they were negotiating the complicated health and welfare system. Other women spoke of simpler forms of this support: particular someone who was supportive, listened and treated them with dignity and respect.

In reflecting on her escape from an abusive partner, Kim believed that without a lot of support from services, women were likely to remain living with domestic violence. The greatest support and assistance that Kim described was on a personal level when a female psychologist offered her holistic care (which also extended to Kim's children) as well as assisting with the confidence boost that Kim needed by acknowledging her strengths.

She acknowledged my strengths, abilities and personal resources, and built on these aspects little by little. (She) gave me information, books to read, sometimes gave me the words to say...encouraged me to tap into my feelings and intuition, which I had ignored for so long, and soon the real person started to emerge. Last year I sought a divorce all by myself! (Kim).

Gail described the refuge she was staying in at the time of her interview as 'the best' she had ever been to and talked about the staff members taking her back and forth to appointments and providing childcare for her children, a major help as she had very limited support from her family and friends. Abigail also talked about instances where she was complimented by staff at the refuge. Reflecting on her past, she talks about having felt like she needed validation from a man in her life and the compliments from the workers at the refuge went a long way to build her confidence and repair self-esteem.

Because I have limited support or no support at all from my family, and my close friends because I burnt all my bridges, they basically build me up to where I can become something without me having to think I need a man to give me that boost. 'oh do I look good today love?,' oh beautiful', 'oh thank you!'

Carla talked about working with caring service providers who understood her and made her feel safe. Most importantly, she described working with one counsellor in particular whom she felt would do ‘anything’ for her. Carla contrasted this with other counsellors who were unable to separate the woman from the mental health issue – realising that there was a woman with her own story involved rather than just a ‘case’.

Proactive, informed services and staff

Women suggested that service providers be more proactive and provide increased outreach in the form of referrals or direct contact. The alternative for many of these women was to draw on their own strengths and resources to locate assistance (housing, financial, therapeutic). This type of ‘help’ from service providers, went a long way to ‘recharge’ some women who had very little strength left after leaving the abusive partner, particularly when they were also dealing with mental illness/health concerns.

Gail stressed that services need to be proactive in assisting women and going to them to inform them of services and events, because she believed that women in this situation were likely to be in denial or too fearful to pursue these services on their own.

I think there should be a group that, when something like that is reported, you don't wait for the woman...Nine out of ten times women will not pick up the phone, because they are in denial...You (should) just go to their front door.

Women were positive about working with a specific staff member who they believed was committed to them, their mental health and their journey away from violence. This commitment helped women to feel optimistic, boost their confidence, and be worthy of care. The positive messages provided by workers was in direct contrast to those their abusive partners had been giving.

Katya talked about hearing empty promises – that she was going to be provided with information, assistance in finding accommodation, and help managing the complex bureaucracy of the system. She was unable to find the help that she needed until she came into contact with a service provider who worked holistically. She had faith that this worker would help her with whatever issues she may have had, from big questions or problems to ‘the silly things’. This trust in someone was important for Katya.

What I can say is, since I have been with (worker), I don't need to look for any information. I don't need to bother to pick up the phone. I just say, “(worker), I have this problem,” and my problem is fixed the next day!...Every single issue I have, like the silly things...completely everything!”

Support is available when needed

Women spoke of the benefits of complete support from service providers, stressing frequency of contact as critical. The type of contact they talked about ranged from phone calls to home visits and staff accompanying them to appointments when they needed support. These actions on the part of service providers or the initiative of individual staff members helped women feel protected and supported.

For example, Ilke recalls a worker coming to her house to give her daily doses of medication. She believes that without the support of this person she would not have been able to keep her medication on track. Elly described a 'package' service, in which workers would look after her for a set number of hours each day. She also spoke of a mental health worker who would come to her house to check in with her. Kathy spoke of a service provider who would come to her home to make sure that she was taking her medication regularly. As Kathy put it, she felt scared often as part of her illness as well as a consequence of her abuse. Someone coming to help her with her medication helped her manage these feelings.

A Crisis Team is a really good idea because just having a couple of people coming, it can diffuse a situation if it is a major emotional drama. It is always handy having someone coming to give you your drugs too. If you were scared....if I am at all off the air I may not remember if I have taken them.

Gail talked about a particular service worker who would phone her to check in, with conversations sometimes lasting for hours. She found this very comforting, because it meant that she did not have to get dressed and go out in public if she was not feeling well enough.

We would talk for hours over the phone, which was very comforting because I didn't have to get dressed and go out in public. I would go to court with her and she would pick me up and drop me off at home.

Flexibility

Most women saw staff and organisational flexibility as positive aspects of service delivery. This flexibility was talked about in direct contrast to the bureaucratic rigidity of some organisations, where women had to negotiate through a mountain of 'red tape'.

Ilke experienced flexibility with the staff members at the refuge where she was staying:

You are only allowed to stay here for two months but they had a meeting for me. I was approved to stay for as long as I needed to which has been three months, two weeks and two days.

Elly felt positive about the care she received from a mental health team, which she found to be flexible. She talked about how staff members at the service would obtain necessary information from their client's doctors and were able to intervene in a crisis situation, rather than asking the patients to wait for sometimes weeks to get an appointment.

I found them useful because, if you get to know them and they can talk to your doctor and give permission to read your files, and if ever you are in trouble rather than having to wait to see your doctor, you can call up the crisis number and they will come out and it means they have access to know what to give you in way of medication. If you are short or if you need extra, rather than having to wait days or weeks before you can see your doctor so it does help the Mental Health teams to be a part of your life, and just for people to talk to, counselling.

Rather than keep her appointments in the 'dingy' rooms at the health centre, Linda described how her caseworker would take her out to coffee somewhere nice, just to make the meeting more relaxed and special for her. Linda also talked about the refuge where she stayed, despite having a roster for chores, the staff members were flexible and allowed women to switch days/times if they had appointments or prior commitments. She contrasted this with a previous refuge which did not offer any flexibility to their clients.

'We get strong from hearing each others' stories'

Many women (such as Sangeeta quoted above) talked about how helpful it was for them to meet with other women who had escaped domestic violence, to learn from their experiences and model themselves after their successes. Some women who had not had contact with other survivors suggested this as a move forward in their journey away from violence. Women also talked about mental health support groups where women facing similar issues could come together to support each other.

Dianne spoke about the benefits of meeting with women who've been victimised and being able to learn from their experiences. She felt that if one woman had gained useful

information from a course or counselling session, that she could pass it along to the other women and together form a community of women helping women. Dianne talked about being able to make friends through these group sessions and how hard it was to get through recovery when you felt you had no friends.

I think women need to be around other women [for] whom it has happened as well. It helps them to move on. They form more friends. Like I think the hardest thing is you haven't got many friends, and to go to a place like that, you will find more friends. You will meet people, do you know what I mean? If somebody has a little more knowledge on what to do then they can pass it onto that lady then that lady..

Like several of the other women, Sally talked about feeling connected to other women she had met through programs organised by the refuge because they had been through similar experiences of domestic violence. She felt empowered by this group and supported in her responses and actions towards her abuser. Sally also talked about how a group of this nature could serve to build up the self-esteem of abused women.

[You] go to this [women's support] group and it empowers you and eventually you have a block there and you have the power in that situation and you knew who you were. You knew he wasn't allowed to do that and stop making excuses for him.

Linda spoke very positively about her support group for women with mental health concerns. They met informally once a week but also socialised together during the week. She found the group to be of great benefit to women trying to manage their mental illness, as they had similar issues and provided each other with support, advice, and a shoulder to lean on.

Building a new life

Women described the benefits of services available to victims of domestic violence offering assistance or courses which taught life skills to their clients as a means to foster and encourage independence in their new lives as women free from abuse and, for most, newly single.

For example, Abigail explained how the refuge she was staying at taught her budgeting and time management skills, which helped her to deal with the stresses of her situation by not introducing additional preventable stresses such as missing appointments or finding herself with no money. She also spoke about the benefits of the parenting program that they offered. Most importantly, Abigail discussed the powerful psychological benefits that

being given her own space at the women's refuge had for her, namely giving her a sense that she had control over her environment and her life.

It is your own little home inside those bedrooms...The thing is, when women leave domestic violence – I know for me, materially I have lost everything – so it is good for me to be able to come into my room and see what I have achieved in the last few weeks. I sit here and watch my little t.v. and I don't have to go out there to make a coffee because I have got a kettle here.

When asked how services could be improved, Dianne suggested incorporating life skills education into a support program for victims of domestic violence in order to help counter the psychologically damaging effects of that abuse, specifically a lack of confidence resulting from years of negative treatment. As she put it, she felt scared of men that she encountered in the outside world and felt that some help reintegrating into society would be useful for women in her situation. Dianne speculated that part of the reason that abused women went back to live with their abusers was due to financial need resulting from difficulties obtaining work related to the above issue.

That side of it and also getting you back into the world because I haven't worked for so long. Like for me to go out to that shopping centre, you just feel like a little mouse. You are scared. This big man comes through the check out and you have got no confidence because the man you have been with for eighteen years has taken all of that away from you, do you know what I mean? Even just to have a support where you can start out with jobs, just to get back into the world.

Working with all parts of me

She did everything! She did my diet, my sleeping, relaxation. She put me onto going to a chiropractor and my children go as well... She acknowledged my strengths, abilities and spiritual resources – and built on these aspects (Kim).

Women talked about the importance of health professionals working holistically with them, looking at all aspects of their health, often using non-traditional therapies to help with the trauma associated with domestic violence and mental illness/health concerns rather than just prescribing medication.

Katya's counsellor provided her with relaxation tapes and equipment on which to listen to them. She was also able to access acupuncture treatments, massage therapy and a naturopath through a domestic violence service which she found very useful. As she puts

it:

It was really very helpful because they (counsellors) talk to me like adults. I know just what is happening...If it makes me feel better, then I accept it straight away.

Spreading the word

Women believed in the importance of an increase in public awareness, through education and public campaigns, to further general understanding and identification of domestic violence. Emotional abuse as a form of domestic violence was targeted as an area where more public awareness was particularly needed as many of the women spoke of not having identified their own abuse as domestic violence, especially in incidences where they were not physically abused.

Despite knowing that it felt wrong, Denise did not realise that what was happening to her was domestic violence until she began to read pamphlets on the subject, which taught her about the various forms of domestic violence. Not surprisingly, when asked about ways in which current services could improve, Denise talked about the need for promoting information about the different forms of abuse and suggested that pamphlets be provided in doctors' waiting rooms, hospitals, and as many places as possible where women might pick them up and leaf through them. She also suggests that information should target the connection between domestic violence and mental illness/health concerns for women who have experienced domestic violence.

Brooke believed that education should begin in the early years of schooling so that young people would have the knowledge to identify domestic violence and would develop the tools to foresee abusive partner's behaviour in future relationships. She talked about women feeling that the abuse was normal or that they deserved it. She felt that education would empower young women to ask those initial questions and seek out the information that they needed to help themselves out of an abusive situation or leave before the violence escalates. She asked that:

Girls and boys are educated on the characteristics of it (domestic violence) so then: 1. they can work it out for themselves if they've got them, and 2. girls are clued into them. If they are ever in this situation they could think, 'Four years back in high school I remember something like this.' That could be enough for them...rather than getting used to it and learning to adapt to it.

Brooke views the issue of domestic violence as a community issue – not just an individual’s problem. As such, she also called for increased information and public campaigning against domestic violence to be included in magazines, milk cartons, ‘everywhere!’.

Similarly, Lily called for an increase in public campaigns as she felt that the lack of public information about domestic violence helped to contribute to stigmatisation of victimised women. Duyen suggested that more information about domestic violence would be useful for women in the midst of an abusive situation. Similar to Brooke, Duyen wanted to see information about domestic violence in many places including television ads and pamphlets in public places such as doctors’ offices. Duyen also stressed that emotional violence be included as a form of domestic violence.

Lea talked about the fact that domestic violence was still happening after so many generations as proof that current anti-violence initiatives were not doing enough. To improve the current situation, Lea talked about secondary school education to help solve the problem of domestic violence through information dissemination and pamphlets or other handy sources of information which could get people thinking about the issue. Lea also commented specifically on using education as a way to stop domestic violence at its root by getting to the young men themselves and stopping, what she hypothesised might be, the cycle of violence in women’s lives.

WOMEN'S RECOMMENDATIONS

Messages from the women to service providers:

- Believe us and treat us with respect
- Work collaboratively between the two sectors, communicating with each other about us. Coordinate your services and have a clear understanding of the nature of each other's service
- Work together to help us navigate the complicated system
- Respect our own understanding of our mental health concerns/mental illness and work with us on our recovery, rather than establishing a controlling relationship over us
- Don't blame us for our situation, either our mental illness/health concern or for the relationship where we experienced domestic violence. Don't blame us for staying in the relationship
- Be aware of the mental health implications for us when we have experienced domestic violence – that way addressing probable causes of the mental illness/health concern rather than just treating the symptoms
- Be aware of the abuser's tactics to use the mental illness/health concern to further entrap us. Be aware of abusers interference in our mental health treatment and to help us through these times by supporting and believing us
- Work with us in a holistic way, integrating a wide variety of techniques/interventions to address the trauma caused by the domestic violence and mental health concerns
- Always use interpreters when we have difficulties understanding English and try to understand the cultural intricacies with women from a CALD background

GLOSSARY OF TERMS

Mental Illness: The full range of recognised, medically diagnosable illnesses that result in significant impairment of an individual's cognitive, affective or relational abilities

Mental Health Concern: Diminished cognitive, emotional or social abilities, but not to the extent that the criteria for a medically diagnosed mental illness are met

Aboriginal Mental Health: Aboriginal people have adopted a holistic view of mental health which means that mental health is part of full health which is defined as “not just the physical well-being of the individual but the social, emotional and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life”

Domestic Violence: Violent abusive or intimidating behaviour carried out by an adult partner against a partner or former partner to control and dominate that person. Domestic violence causes fear, physical and/or psychological harm. It is most often violent, abusive or intimidating behaviour by a man against a woman. Living with domestic violence has a profound effect upon children and young people. Some other communities use the term ‘family violence’

Domestic violence services: in this report we refer to domestic violence services as those services that assist women when domestic violence has occurred. Services include: women's refuges, court support, women's health centres, counselling services, specialist domestic violence services, domestic violence outreach services, and family support services. Police and DVLOs are referred to separately.

Mental health services: include any service that assisted a woman with her mental health. Examples include: community mental health services, in-patient units, mental health NGOs, and psychiatrists employed under NSW Health area mental health services, private psychiatrists and GPs.

Perpetrator/abuser: that person recognized and described by the interview participant as the one perpetuating abuse and violence against her.

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APPENDICES

Interview Guide: Women

Preamble

Thank you for agreeing to be interviewed today. As you know, I am interested in hearing about your experiences with both domestic violence and mental health services. There are no right or wrong answers in this — it's all about what you think or feel. However, if you do not want to answer some of the questions I ask you, that's fine — just let me know. From time to time I'll check with you about how you are finding the interview.

- Can you start by telling me about any services that you've had contact with in seeking help with either domestic violence or mental health concerns. This includes services where you tried to get help, but weren't able to.
- Explore, for each service mentioned, if not elicited by this open question:
 - Nature of involvement with the service (how informed about the service; referral processes; type and length of contact; reasons for seeking help from this agency at this time)
 - What was it like for you, approaching the service for the first time? Did you have any particular hopes or fears about what would happen when you made contact? How did these go?
 - What, if anything, was helpful about the contact that you had with the service?
 - What, if anything, could have gone better/been more helpful to you, about your contact with the service?
 - Did the service refer you to any other agencies/people? How did that work out (for each agency)? Could anything have been done by the service to assist things to go more smoothly?
 - Were there agencies/people that you should have been referred to, but this didn't happen? What was that like?
- If you could design a system that would offer the best help possible for women dealing with both domestic violence and mental health issues, what would it be like?
- What, if any, key messages would you like to give to those departments or services who have contact with women who are experiencing domestic violence and mental health issues? To other women dealing with similar issues in their lives?
- Now a few questions about your living situation (if this has not come up previously). Are you still living with your husband/partner/etc? Do you have children living with you? How old are they?
- How has it been for you today, doing this interview?



The University of Sydney

AN OPPORTUNITY TO HAVE YOUR SAY

in a research study about Mental Health and Domestic Violence Services

WHAT IS THE STUDY ABOUT?

Improving mental health and domestic violence services for women.

WHO CAN PARTICIPATE?

Women who are eighteen years and older and who:

have experienced domestic violence that has affected their mental well-being, OR

have been clients of mental health services and who have also had problems with domestic violence, OR

have used a domestic violence service and have also had mental health issues.

WHAT IS INVOLVED?

An interview with Jude Irwin, Lesley Laing or Cherie Kennaugh from the Faculty of Education and Social Work, University of Sydney. This will take up to an hour.

The location of the interview will be discussed with you to ensure that the place provides safety and confidentiality

PARTICIPATION IS VOLUNTARY AND CONFIDENTIAL

FOR FURTHER INFORMATION:

Phone Cherie on 02 9351 6434.



The University of Sydney

PARTICIPANT INFORMATION SHEET

Interviews with Women

Title: Towards Better Practice: Enhancing collaboration between mental health and domestic violence services

(1) What is the study about?

This project aims to improve the availability and quality of services for women experiencing domestic violence and mental health issues. This is part of a larger project which also seeks service providers' ideas about ways to improve services.

(2) Who is carrying out the study?

The study has been funded by the Australian Research Council and is being conducted by Dr Jude Irwin, Dr Lesley Laing and Dr Lindsey Napier in conjunction with Joan Harrison Support Services for Women, The Education Centre Against Violence, The Transcultural Mental Health Centre and the Fairfield /Liverpool Mental Health Service.

(3) What does the study involve?

The study involves participating in an individual interview. The interview will explore your experiences and views of the responses you have received from mental health and domestic violence services. If you agree, the interviews will be audio-taped and transcribed. If you wish, a copy of the transcript will be provided to you and you may make corrections or changes.

(4) How much time will the study take?

Participating in an interview is expected to take about one hour.

(5) Can I withdraw from the study?

Participating in the study is completely voluntary. You are not under any obligation to participate. If you do decide to participate and change your mind you can withdraw from the study at any time even during or after the interview. Whatever your decision about participation, it will not affect your access to mental health and domestic services.

(6) Will anyone else know the results?

All aspects of the study will be strictly confidential and only the researchers will have access to information on participants. There may be publications from the study but individual participants will not be identified.

(7) Will the study benefit me?

This project will have benefits for both women who experience domestic violence and mental health concerns and for practitioners who work in the area. It will increase knowledge about how to respond to women in this situation.

(8) Can I tell other people about the study?

You may tell other people about the study and if they wish to obtain further information they could contact Dr Lesley Laing on 93514091.

(9) What if I require further information?

If you require further information about the study please contact Dr Lesley Laing who will discuss it with you and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Dr Laing on 93514091.

(10) What if I have a complaint or concerns?

Any person with concerns or complaints about the conduct of a research study can contact the Manager, Ethics Administration, University of Sydney on (02) 9351 4811.

This information sheet is for you to keep



The University of Sydney

Participant Consent Form

I give consent to participation in an **individual interview** in the research project. **Towards Better Practice: Enhancing collaboration between mental health and domestic violence services.**

In giving my consent I acknowledge that:

- The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.
- I have read the Participant Information Sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher.
- I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher now or in the future.
- I understand that my involvement is strictly confidential and no information about me will be used in any way that reveals my identity.

Signed:

Name:

Date: